Appendix 4

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Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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Wisconsin Medicaid
Electronic Media Agreement

WHEREAS, (1)_____, hereinafter referred to as "Provider," desires to submit claims electronically to Wisconsin Medicaid, or has entered into an arrangement which gives another party, hereinafter referred to as "Billing Service," authorization to submit claims on the Provider's behalf to Wisconsin Medicaid; and

WHEREAS, the Wisconsin Department of Health and Family Services (Department) through its Division of Health Care Financing (DHCF), is satisfied that the Billing Service is capable of complying with the format, content, and procedural requirements of DHCF for electronic billing;

NOW THEREFORE, the Provider and DHCF agree as follows:

I. DHCF approves of the Provider's intention to submit claims through electronic media, said approval being subject to the Provider's and Billing Service's compliance with the format, content and procedural requirements of the Department for electronic media or electronically transmitted claims submission, including subsequent revisions thereto by the Department.

II. In accordance with HSS 106.03(2)(c), Wis. Admin. Code, the Provider shall be solely responsible for the truthfulness, completeness, timeliness and accuracy of any claim submitted directly by the Provider, the Provider's Billing Service, or by another agent of the Provider. Provider shall indemnify the Department for any cost the Department incurs for processing, auditing, and/or paying claims that repeatedly lack truthfulness, completeness, timeliness or accuracy, whether submitted directly by the Provider, the Provider's Billing Service or any other agent of the Provider.

III. All costs for claim preparation and submission shall be the sole responsibility of the Provider or Billing Service and are not chargeable to the Wisconsin Medicaid. In accordance with HSS 106.03(5)(c)2, any payment for the billing or collection of payments for Medical Assistance services must be unrelated, directly or indirectly, to the amount of payments on the claims for them, and is not dependent upon the actual collection of payment.

IV. The Provider shall be solely responsible for any obligations it has pursuant to its Provider Agreement with Wisconsin Medicaid, specifically including but not limited to Wisconsin Medicaid medical and financial recordkeeping and documentation requirements in s. HSS 106.02, Wis. Admin. Code, the claims submission requirements of HSS 106.03, Wis. Admin. Code, and the responsibility to return overpayments according to the requirements in s. HSS 106.04, Wis. Admin. Code.

V. If the billing arrangement with the Billing Service is terminated, the Provider shall immediately report the termination in writing to the Department's Fiscal Agent.

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Wisconsin Medicaid Electronic Media Agreement Form Continued

VI. The Department may at its sole discretion terminate this agreement and revoke the Provider's approval for electronic media claims submission at any time if the Provider or Billing Service: a) fails to comply fully with any laws, rules or Wisconsin Medicaid guidelines (including Wisconsin Medicaid handbooks and bulletins) governing the preparation or submissions of claims, or b) repeatedly submits duplicate, inaccurate or incomplete claims.

VII. The Department may at its sole discretion terminate this agreement and revoke the Provider's approval for electronic claim submission when the Provider's claim repeatedly fails to provide correct and complete information necessary for timely and accurate claims processing and payment in accordance with billing instructions provided by the Department or its Fiscal Agent.

AGREED TO by the Department, through its Division of Health Care Financing, and the Provider on the dates indicated below the signatures for each party:

(2)_____	(4)_____
Provider	Division of Health Care Financing Department of Health and Family Services
(3)_____	(5)_____
Date	Date

(To Be Completed by Providers Using Billing Services)

The Provider hereby certifies that (6)_____ is authorized to submit claims on
(Billing Service)
the Provider's behalf.

The Provider (7)_____direct Wisconsin Medicaid's fiscal agent to return claim payment and denial
(does/does not)
data on cartridge to the above-referenced billing service.

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Wisconsin Medicaid Electronic Media Agreement Form Continued

(To Be Completed by All Providers or Authorized Agents)

(8) Provider Name:_____

(9) Provider Address:_____

(10) City, State, ZIP:_____

(11) Group Provider Number (if applicable):_____

(12) Individual Provider Number:_____

(13) Authorizing Signature:_____

(14) Date:_____

After completing this form, please return to:

Wisconsin Medicaid
EMC Unit
6406 Bridge Road
Madison, WI 53784-0009

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Wisconsin Medicaid Electronic Media Agreement Form Instructions

Use the instructions below for completing the Electronic Media Agreement Form.

Providers should submit the Electronic Media Agreement Form with the Electronic Billing Software Request Form located in Appendix 3 of this section. Providers are not required to contact the EMC Unit prior to completing and submitting the Electronic Billing Software Request Form and the Electronic Media Agreement Form.

(1) Provider Name

(2) Provider Name

(3) Date of Completion

(4) Leave Blank

(5) Leave Blank

(6) Only to be completed by providers using billing services. Enter the name of the billing service you authorize to submit claims.

(7) Only to be completed by providers using billing services.

Enter "DOES" to authorize the billing service to receive a copy of finalized claims data on cartridge. Providers using this billing arrangement will still receive a paper Remittance and Status (R/S) Report and payment.

Enter "DOES NOT" if you do not want the billing service to receive a copy of the Remittance and Status (R/S) Report on cartridge.

(8) Provider Name

(9) Provider Mailing Address

(10) Provider City, State, and ZIP Code

(11) Group provider number if affiliated with a clinic, if applicable

(12) Your individual provider number (if you have two billing numbers, you must complete two forms)

(13) Provider authorized signature must be handwritten. The Medicaid fiscal agent must have the original authorized signature on file

(14) Date of completion